Volume 10 / Number 2 / March – April 2001

# FOCUS

*Communicating NCID's prevention and control programs for emerging and reemerging infectious diseases*

## Message from the Director

Dear Colleagues:

NCID recently held its annual Program Briefing for Dr. Koplan, emphasizing selected accomplishments from the past year and our challenges for the year ahead. The briefing focused on six areas: foodborne illness in the United States, drug-resistant *Staphylococcus aureus* infections, hepatitis C, informatics as a public health tool, diseases of public health concern among U.S.-bound immigrants and refugees, and integrated disease surveillance and response in the African region.

Areas of special concern this year include building our national capacity to enable us to respond to acts of bioterrorism, continuing implementation of CDC's *Preventing Emerging Infectious Diseases: A Strategy for the 21st Century*, beginning implementation of CDC's components of *A Public Health Action Plan To Combat Antimicrobial Resistance*, and working to improve patient safety through reduction of medical errors.

Each year we must renew our commitment to the prevention and control of a growing number of infectious diseases. We look forward to another year of working with our CDC colleagues and our many partners as we continue our efforts to prevent and control these emerging threats to national and global health.

*James M. Hughes, M.D.*

*Focus on Global Health*

## DVRD, DHQP assist in project to combat hepatitis C in Egypt

In Egypt, hepatitis C virus (HCV) infects an estimated 10%–15% of the general population (compared to approximately 2% in the United States), and chronic liver disease is a leading cause of disability and death. Unsafe injections in health care settings and other improper infection control practices may be contributing to the ongoing transmission of viral hepatitis in Egypt.

As part of an effort initiated by the U.S. Naval Medical Research Unit 3 (NAMRU 3) in Cairo, Egypt, and in collaboration with Egypt's Ministry of Health and Population, NCID is assisting in a pilot project to improve infection control practices in Egyptian health care facilities and thereby reduce the transmission of HCV and other bloodborne pathogens. The project consists of four phases: baseline assessment of infection control practices, intervention design, implementation, and evaluation.

In October 2000, Amy J. Khan and Dejana Selenic, EIS Officers assigned to the Division of Viral and Rickettsial Diseases and the Division of Healthcare Quality Promotion, respectively, went to Egypt to provide technical assistance in the development of a tool to assess

*continued on page 2*

*Safe injections and other infection control practices are one focus of this project to control the spread of HCV.*

*Hepatitis C – continued from page 1*

infection control practices at health care facilities in Egypt. They are participating in the project at the invitation of Frank Mahoney, NCID medical epidemiologist, who is on assignment with NAMRU 3.

Drs. Khan and Selenic visited several health care facilities and trained a team of Egyptian Field Epidemiology Training Program fellows in the data collection protocol during the baseline assessment.

Results from this assessment will be used to describe specific breaks in infection control practices and to direct the second phase of the project involving design and intervention.

"The ultimate goal," said Dr. Khan, "is to reduce the transmission of hepatitis C virus and other bloodborne pathogens in health care settings."

The first phase of the project is expected to be completed by April 2001. ■

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*Focus on Bacterial and Mycotic Diseases*

# Integrated disease surveillance in Africa takes major step forward

The first meeting of the Task Force for Integrated Disease Surveillance (IDS), held November 8–10, 2000, marks significant progress for CDC's long-term effort to strengthen infectious disease surveillance in Africa.

Staff from the Meningitis and Special Pathogens Branch (MSPB), Division of Bacterial and Mycotic Diseases, and from the Division of International Health (DIH), Epidemiology Program Office (EPO) met with African public health officials in Harare, Zimbabwe, to review progress, identify successes and constraints, and provide guidance for the next steps of IDS implementation. The ultimate goal is to reduce or control several infectious diseases that are prevalent on the continent.

IDS is a strategy to improve the availability of surveillance and laboratory data in the Africa region for control of priority infectious diseases.

Specific goals of the program are to strengthen district-level surveillance and response for priority diseases, to integrate surveillance with laboratory support, and to translate surveillance and laboratory data into specific public health actions.

The strategy grew out of efforts in the early 1990s to improve control of meningococcal disease epidemics in Africa. These efforts resulted in the development of meningitis surveillance thresholds–levels of incidence of new cases in an area, which, if surpassed, would trigger mass vaccination campaigns.

In 1998, the African Regional Office (AFRO) of the World Health Organization adopted the IDS strategy to focus on 19 priority diseases using the principles that were developed for meningitis control. The IDS-targeted diseases include epidemic prone diseases, diseases targeted for elimination or eradication, and other diseases of major public health importance.

*Members of the CDC IDS team with director of IDS efforts at WHO/AFRO. Front row: Helen Perry, Kathy Cavallaro, Montserrat Soriano-Gabarro, Peter Nsubuga, Antoine Kaboré (WHO/AFRO). Back row: Bradford Kay, Bradley Perkins, Lorrie Gavin, Mac Otten (NIP).*

CDC has been providing technical assistance to AFRO for IDS since 1998 through a unique partnership between NCID and EPO.

Bradley Perkins, chief, MSPB, and Sharon McDonnell, DIH, have provided leadership for CDC's part of the project. Other members of the IDS team include Peter Nsubuga and Helen Perry (DIH) and Bradford Kay, Montserrat Soriano-Gabarro and Kathy Cavallaro (MSPB). CDC has assisted with surveillance and laboratory assessments, plan of action development, laboratory strengthening, and the development of technical guidelines for IDS. ■

Focus on Vector-Borne Infectious Diseases

# National meeting reviews U.S. plans for protecting against West Nile virus

Approximately 300 scientists met in Charlotte, N.C., January 31–February 4 to update national guidelines for the surveillance, prevention, and control of West Nile virus infection in the United States. The meeting was organized by the Association of Public Health Laboratories and the Division of Vector-Borne Infectious Diseases (DVBID) and cosponsored by 10 other federal agencies and national professional organizations

The meeting focused on guidelines recommended by experts at a similar meeting in November 1999, soon after outbreaks of West Nile disease had occurred among humans, horses, and birds in the northeastern United States. The outbreaks marked the first time West Nile disease had been reported in the Western Hemisphere.

West Nile virus is a flavivirus spread to humans, birds, horses, and other animals by the bite of infected mosquitoes. Infection in humans usually does not cause severe illness, but it can lead to encephalitis, meningitis, and even death. No treatment or vaccine exists for West Nile encephalitis.

In 1999, 62 cases of acute West Nile neurologic illness, including seven deaths, were reported in New York City and surrounding counties; in 2000, only 21 human cases, including two fatalities, were reported from New York City, New Jersey, and Connecticut. However, because severe disease develops in only a small fraction of infected people, public health officials estimate that a substantially higher number of people were infected with the virus in both years. In addition, high rates of illness and death caused by West Nile virus occurred in birds, horses, and other animals. The geographic range of West Nile virus infection expanded from four states in 1999 to 12 states and the District of Columbia in 2000.

In response to the emergence of West Nile virus in the United States, federal, state, and local agencies have worked together to develop programs for monitoring West Nile virus activity and for preventing future outbreaks. DVBID has coordinated much of this effort and has provided funds to states and cities to support local programs for West Nile virus and other mosquitoborne viruses.

Experts at the meeting in Charlotte discussed ways to strengthen current activities in the areas of ecology and biology, surveillance, diagnostics, public health infrastructure, and prevention and control. A report based on their recommendations is expected to be completed within the next few months. ■

# The hallmark rash of Lyme disease may be caused by more than one spirochete

Lyme disease typically begins with a characteristic, expanding skin rash. This rash, called erythema migrans (EM), is caused by infection with *Borrelia burgdorferi*, a spirochetal bacterium introduced into skin by deer tick bites. Sometimes patients, particularly those in southeastern and south-central states, develop what looks like EM, but evidence of infection with *B. burgdorferi* is lacking. This situation has caused confusion and controversy about whether Lyme disease can be acquired in southern states.

New evidence from the Division of Vector-Borne Infectious Diseases (DVBID) in Ft. Collins, Colo., and collaborators at New York Medical College in New York City suggests that EM may have more than one cause. DNA sequences of a recently identified spirochete, *Borrelia lonestari*, were detected in the skin of a patient who had a rash clinically indistinguishable from EM. A lone star tick (*Amblyomma americanum*) was still attached to this patient when he sought medical care. DVBID investigators were able to find the same DNA sequence of a *B. lonestari* gene in the tick and in the skin biopsy sample. Laboratory tests (culture, PCR, and serologic testing) did not support a diagnosis of *B. burgdorferi* infection.

These observations are a first step toward answering the question of whether *B. lonestari* is a new tickborne pathogen of humans in the United States, explains Barbara Johnson, chief, Molecular Bacteriology Section, DVBID. This hypothesis is appealing because there are several published papers on suspected Lyme disease cases in southern states that report patients with EM rashes at the site of a proven or suspected lone star tick bite. However, laboratory studies indicate that lone star ticks do not transmit *B. burgdorferi*.

Not much is known about *B. lonestari*. Researchers have not yet been able to culture it or develop a serologic test for infection. The spirochete is identified only by PCR amplification of two genes, procedures developed by Alan Barbour of the University of California, Irvine, and DVBID scientists, working with extracts of infected ticks. Only 1%–3% of lone star ticks, depending on geographic site of collection, are infected with the spirochete.

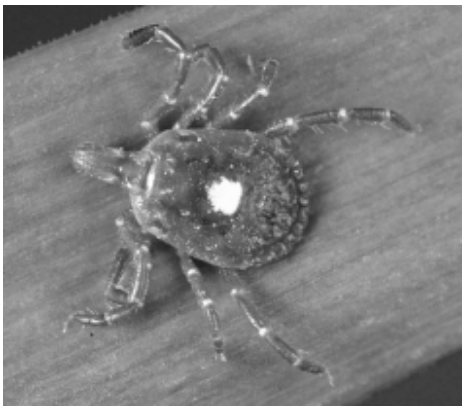
*continued on page 4*

*Lyme disease – continued from page 3*

Barbour demonstrated by analysis of 16S rRNA genes that *B. lonestari* is more closely related to the relapsing fever spirochetes than to *B. burgdorferi*.

Most tick bites in humans in the southern United States come from lone star ticks. So far, *B. lonestari* has been found in ticks from Texas, New Jersey, Alabama, and probably North Carolina (the likely site of infection of the case-patient whose skin was evaluated by PCR).

In some states, such as New Jersey, deer ticks infected with *B. burgdorferi* and lone star ticks infected with *B. lonestari* may coexist. In such areas, it is possible that two different *Borrelia* species may cause EM, and not all EM will indicate Lyme disease. Efforts are underway to assess the public health importance of *B. lonestari* infection through both intramural research and cooperative agreements with academic laboratories. This assessment involves clinical and epidemiologic studies and field investigations of vector ticks and their hosts. ■



*Adult lone star tick (*Amblyomma americanum*)*

*Focus on Viral and Rickettsial Diseases*

# U.S. surveillance finds no evidence of domestic new variant Creutzfeldt-Jakob disease

Amid growing public concern about the spread of bovine spongiform encephalopathy (BSE), or mad cow disease, in Europe, officials at CDC and several other U.S. agencies are maintaining a vigilant watch for the emergence of both BSE and its human counterpart, new variant Creutzfeldt-Jakob disease (nvCJD), in the United States. Several recent events have focused attention on the public health threat posed by BSE, most notably:

- reports of new BSE cases among cattle in Germany, Italy, and Spain and of increased incidence in several other countries;
- recommendations of emergency measures by the European Union to test all food animals over 30 months of age for BSE and to suspend feeding protein to food animals;
- the release of a U.S. Government Accounting Office (GAO) report in September 2000 describing the need for stronger and more consistently applied controls to ensure the safety of animal feed in the United States and an announcement in February 2001 of a follow-up GAO investigation of U.S. livestock feed regulations and practices;
- issuance of an emergency declaration by the U.S. Department of Agriculture in July 2000 to acquire sheep in Vermont that had possibly been exposed to the agent BSE.

In the United States, several agencies, including CDC, the Food and Drug Administration, and the U.S. Department of Agriculture, look for domestic cases of BSE or nvCJD. "There is no evidence that either BSE or new variant CJD currently exists in the United States," said Ermias Belay, a medical epidemiologist in the Division of Viral and Rickettsial Diseases' (DVRD) program activity that conducts surveillance for the classic form of CJD–a fatal neurologic disease that is distinct from nvCJD.

Shortly after the reported emergence of nvCJD in the United Kingdom in 1996, CDC enhanced its CJD surveillance system by establishing the National Prion Disease Pathology Surveillance Center at Case Western Reserve University, in collaboration with the American Association of Neuropathologists. CDC also worked with state health departments to initiate follow-up investigations of CJD deaths in persons younger than 55 years of age. A CDC article published in *JAMA* last November stated that these improved surveillance efforts had detected no signs of nvCJD in the United States. The report was coauthored by Robert Gibbons, Robert Holman, Dr. Belay, and Lawrence Schonberger, DVRD.

In response to heightened concerns about nvCJD, CDC is exloring ways to further enhance surveillance for the possible emergence of this disease in the United States. "We would like to encourage more autopsies and maintain a high level of suspicion among U.S. physicians who might treat patients with CJD," said Dr. Schonberger, who leads DVRD's prion disease group.

Additional information about BSE and nvCJD can be accessed on the CDC Web site at http://www.cdc.gov/ncidod/diseases/cjd/cjd.htm. ■

First identified in Great Britain in 1986, BSE is a progressive neurologic disease of cattle that results from infection by an unconventional transmissible agent called a prion. The disorder has affected more than 180,000 cattle in Great Britain, and cases of BSE have been identified in 12 other European nations. In 1996, British scientists reported the first human cases of nvCJD, a fatal neurodegenerative disease linked to BSE, most likely through the consumption of BSE-contaminated beef products. As of March 7, 2001, 99 cases had been reported: 95 in the United Kingdom, 3 in France, and 1 in Ireland. Surveillance data show an increasing trend for the nvCJD outbreak in the United Kingdom.

# CDC's building plan moves forward

As CDC's building plan moves forward, many NCID laboratorians are anticipating the end of their days in cramped, outdated working spaces. Although construction can be an inconvenience, up-to-date laboratory space promises to be worth the wait. To keep you informed about the progress of the building plan, future issues of *Focus* will feature regular updates.

**Roybal Campus**

Work continues on Building 17, the Edward R. Roybal Laboratory Building. Phase 1 opened in September 2000, and construction for phase 2 should be complete by late spring. Move-in for phase 2 is scheduled to begin by September 2001. Staff from the Division of Viral and Rickettsial Diseases, the Division of Bacterial and Mycotic Diseases, the Division of Healthcare Quality Promotion, and the Division of AIDS, STD, and TB Laboratory Research will occupy the new space.

Safety is a top priority in the new building. Phase 2 will contain biosafety level 2 and biosafety level 3 spaces. Like the laboratories in phase 1, the newer part of the building will house a number of large laboratories with room for four people to work, along with many smaller procedure rooms. These smaller areas will be apart from the large laboratories for better containment. Office space is also separated from laboratory space in order to provide better working conditions.

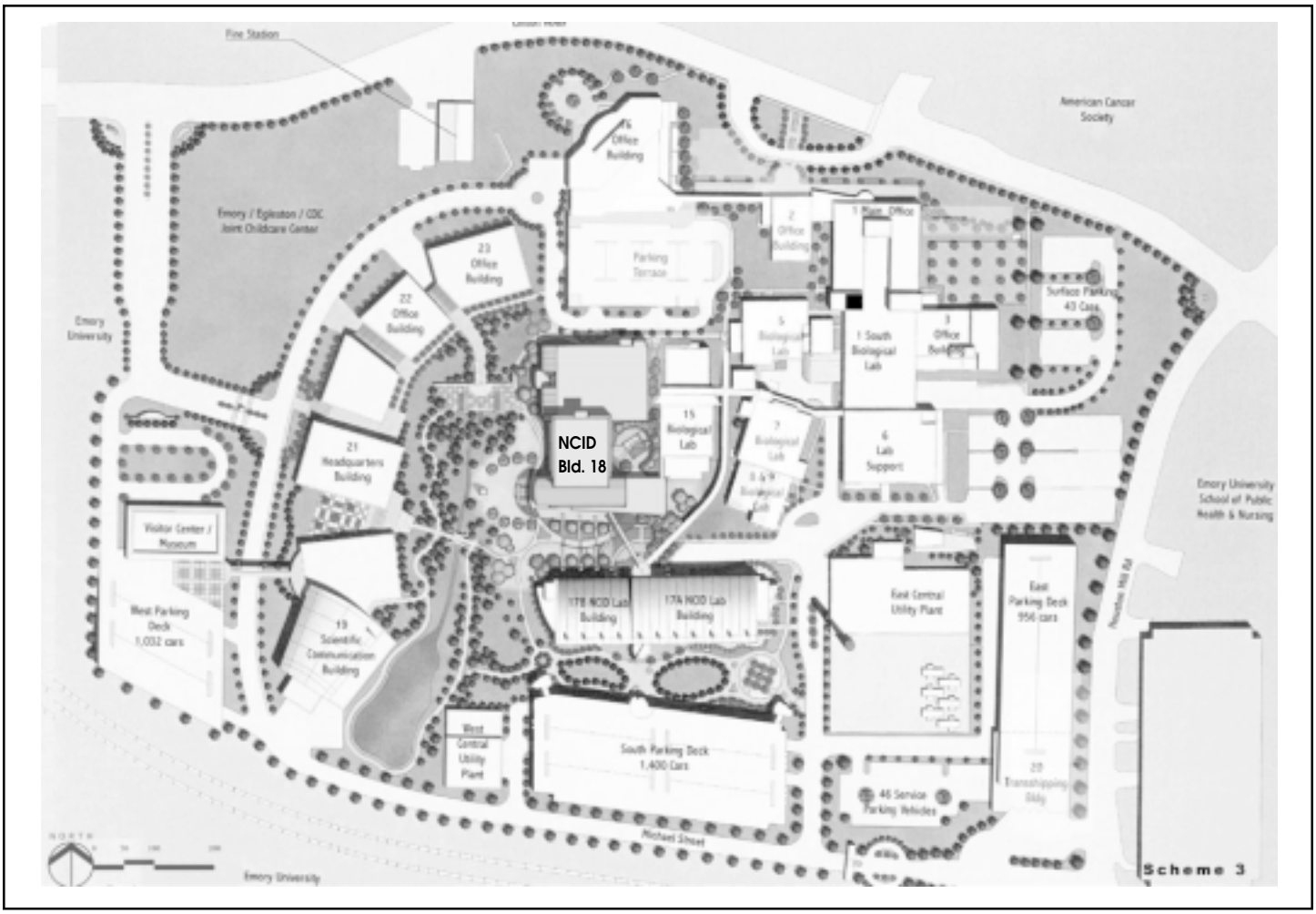
Schematic design has begun on Building 18, another new laboratory building. This site will include laboratories at biosafety levels 2, 3, and 4 and will have space for animals. Construction is slated to begin in the fall of 2001.

**Chamblee**

After a colorful graffiti party send-off, Buildings 6 and 7 at Chamblee were leveled to make way for Building 109, a one-story, biosafety level 2 laboratory. The new building will be constructed in two phases, with the first phase expected to be complete by late 2001. Staff currently working in Buildings 8 and 9 will move into phase A by early 2002.

After phase A is occupied, Buildings 8 and 9 will be demolished, and phase B constructed on that site and joined to phase A.

The new building will house approximately 50 staff members from the Division of Parasitic Diseases. The 27,430-square foot facility will cost just under $9.9 million to build. ■




*CDC's Roybal Campus, as it will look when Buildings 17 and 18 are completed.*

*Focus on Healthcare Quality Promotion*

## Prevention Epicenters meeting focuses on infection control and antimicrobial resistance

The principal investigators from the seven research institutions participating in CDC's Prevention Epicenters Program, along with staff from the Division of Healthcare Quality Promotion, met in Atlanta March 26–27 to discuss ongoing and proposed research efforts to improve health care quality by preventing complications of care, including antimicrobial-resistant infections.

Initiated in 1997, the Prevention Epicenters are supported by CDC cooperative agreements. A principal focus of the Epicenters in the next year will be on the prevention and control of health care–acquired infections caused by bacteria and other microorganisms that have become resistant to antibiotics and other antimicrobial drugs.

"This was the first meeting of the principal investigators since the program received a 5-year renewal," said Steve Solomon, chief of DHQP's Healthcare Outcomes Branch and the coordinator of the Epicenter program. "We discussed several developmental research programs that are underway within the Epicenters program, with a special emphasis on preventing infections associated with medical procedures and interventions and on controlling antimicrobial resistance, especially as it relates to these types of infections."

The Epicenters are a key component of the newly launched DHQP strategic plan for helping the public health system achieve the 50% reduction in medical errors and adverse health events called for in the Institute of Medicine's report "To Err Is Human." A large proportion of these adverse events are infections.

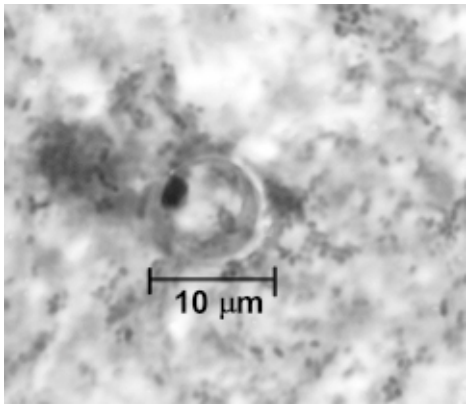
The seven investigators and their respective institutions are as follows: Richard Platt, Harvard Pilgrim Health Care, Boston; Loreen Herwaldt, University of Iowa Hospital and Clinics, Iowa City; Lance Peterson, Northwestern Memorial Hospital, Chicago; Victoria Fraser, Washington University School of Medicine, St. Louis; Trish Perl, The Johns Hopkins Hospital, Baltimore; Edward Wong, McGuire Veterans Affairs Hospital, Richmond, Va.; and Kent Sepkowitz, Memorial Sloan-Kettering Cancer Center, New York. ■

*Focus on Parasitic Diseases*

## DPDx program provides diagnostic assistance in outbreak situations

One service provided by the Division of Parasitic Diseases' (DPD) DPDx program is telediagnosis, based on analysis and exchange of digital diagnostic images of parasites through the Internet. This service can be particularly useful during outbreak investigations, when expeditious identification of the etiologic agent of the outbreak and of cases of infection is essential.

The following example shows how DPDx provides real-time diagnostic assistance for identification of parasites. During the investigation of a recent outbreak of cyclosporiasis, a physician evaluating a patient with a diarrheal illness sent a specimen to the DPD reference diagnostic laboratory. The laboratory confirmed that the patient was infected with the coccidian parasite *Cyclospora cayetanensis*, and images showing the parasite were captured from the microscopic slides and sent electronically to the physician. Confirmation that the patient was infected with *Cyclospora* served to link this patient with an outbreak in another state, which he had recently visited.




*The figure shows a* Cyclospora cayetanensis *oocyst in a stool smear stained with Kinyoun's modified acid-fast technique. The scale bar represents 10 micrometers.*

The DPDx Web site, which went online in March 1998, was designed to provide parasitologists and diagnosticians in the United States and abroad with a source of up-to-date information on diagnosis of parasitic diseases, including text, video clips, and more than 500 images of parasites. To date, 21 state public health laboratories are online with the DPDx program. Most are equipped with a telediagnostic imaging system, which consists of a microscope and a digital camera connected to a computer. Visit DPDx at http://www.dpd.cdc.gov/dpdx. ■

# Tanzania pilot program aims at averting a malaria treatment disaster in sub-Saharan Africa

As resistance to antimalarial drugs intensifies, signs point to an impending malaria disaster in sub-Saharan Africa, where malaria transmission is commonplace and the use of expensive antimalarial drugs is out of reach for many African economies. Malaria Epidemiology Branch (MEB), Division of Parasitic Diseases (DPD), staff members are engaged in a pilot project in Tanzania to evaluate a novel approach to combating this potentially calamitous situation.

Chloroquine-resistant malaria began emerging in Southeast Asia in the 1970s. In the mid-1990s, combination therapy (CT)–mefloquine plus artesunate, a derivative of an ancient Chinese herbal remedy and the most effective antimalarial drug currently available–came into favor. After 5 years of CT use, evidence suggests that the development of resistance has slowed or been halted and malaria transmission rates have been reduced.

Because of the apparent success of CT in Thailand, an international effort is under way to evaluate the safety and efficacy of using CT in Africa. However, malaria transmission is orders of magnitude more intense in sub-Saharan Africa than in Southeast Asia, and the public health infrastructure is not as fully developed. Also, issues of patient and provider adherence to new treatment regimens are a concern.

"Further, CT comes at a cost," said Epidemiologist Peter Bloland. "While not as expensive as mefloquine or other available alternatives to chloroquine or sulfadoxine/pyrimethamine (SP), CT would represent a substantial and possibly unsustainable increase in the cost of malaria treatment. We must have a good idea of whether or not CT, within the context of the African malaria situation, will be successful at slowing resistance before the struggling economies of Africa attempt to rely on it."

Last year baseline activities for a pilot project called the Interdisciplinary Monitoring Project for Antimalarial Combination Therapy (IMPACT) were initiated in four districts in Tanzania to evaluate the effectiveness of CT (SP plus artesunate). Tanzania was chosen because of its high transmission rates and its progressive and committed Ministry of Health and public health officials. The Ifakara Health Research and Development Centre, the National Institute of Medical Research and two of its affiliate projects, the Tanzanian Essential Health Interventions Project and the Adult Morbidity and Mortality Project, along with Muhimbili University, London School of Hygiene and Tropical Medicine, and CDC have joined forces to carry out the evaluation. The project is supported by CDC, USAID, the UNDP/World Bank/WHO Special Programme on Research and Training in Tropical Diseases, and the Wellcome Trust.

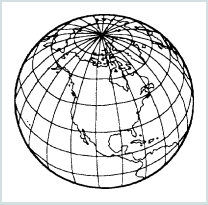
Artemisia annua, *the plant from which artesunate is derived.*

Results from the study will help researchers determine whether the use of CT slows the development of drug resistance; whether CT reduces overall malaria transmission; how behavior, knowledge, preferences, and practices will affect the implementation of CT, what the economic implications of a CT strategy might be to government and households; whether the CT strategy can be both effective and acceptable in a community; and what the public health impact of CT will be.

The DPD team is led by Peter Bloland and includes Holly Williams, who is conducting the policy analysis; John MacArthur, who is monitoring drug efficacy and possible adverse events; Patrick Kachur, who will examine how the new drugs are accepted and used by community members; and Ernest "Chip" Smith, an Emory University Preventive Medicine resident.

The IMPACT-Tanzania evaluation will be carried out over the next 4 to 5 years. ■

*IMPACT-Tanzania team members from CDC are (left to right) John MacArthur, Patrick Kachur, Peter Bloland, Holly Williams, and Ernest "Chip" Smith.*



# Global Health

Although CDC has a long history of responding to outbreaks around the world, we have primarily focused on domestic issues. Recently we have begun to shift toward a global perspective as political boundaries proved to have limited effect on the geographical containment of infectious diseases. Because U.S. and international health care are inextricably linked, Dr. Koplan has made global health one of CDC's top five priorities.

The draft document *Protecting Our Nation's Health in an Era of Globalization: CDC's Global Infectious Disease Strategy* outlines our global objectives, which include a broad range of activities undertaken with partners around the world. The new strategy will expand CDC's role in international infectious disease work to include collaborative projects such as large-scale disease control programs, in addition to continuing work on disease outbreaks and individual research projects.

The draft plan identifies six priorities in global health. These priority areas provide a template for CDC's long-term plan to improve its international capacity to detect, control, and prevent infectious diseases. Focus areas include 1) international outbreak assistance; 2) global disease surveillance; 3) applied research on diseases of global importance; 4) dissemination of proven public health tools; 5) global initiatives for disease control; and 6) public health training and capacity building.

Publication of the final plan for CDC's role in improving global health is expected later this year.

*Scott Dowell*
*Acting Associate Director for Global Health*

*Focus on EID Fellowship Program*

## Laboratory fellows work on West Nile virus surveillance

*by Anne E. Purfield and Jennifer H. Tai*

It came out of the blue–an opportunity to participate in West Nile (WN) virus surveillance at the New York State Department of Health laboratory in September 2000. As Emerging Infectious Diseases (EID) training fellows, we were eager to contribute to the surveillance of this outbreak and gain experience working on WN virus, which first appeared in North America in 1999.

The Arbovirus Laboratory, headed by Dr. Laura D. Kramer, is located near Albany, N.Y., and surrounded by bucolic environs that belie the intense activity inside.

WN virus had spread to all but one New York county, and the lab continued to test samples from all counties and from neighboring states. When we arrived, many mosquito pools and bird samples, as well as samples from various vertebrates, including bats, raccoons, rabbits, cats, and horses, needed to be tested for WN virus.

We were able to participate in every aspect of WN virus surveillance from processing samples to conducting the actual laboratory tests.

Working on the frontlines of a major outbreak was very stimulating. One of the most exciting experiences was confirming that a bat sample was positive for WN virus, marking the first time it had been detected in a wild mammal in the Western Hemisphere.

Our objective at the Arbovirus Laboratory was to assist with the ongoing surveillance effort, while learning as much as possible. We gained not only experience in the laboratory but also new insights into how scientific research and public health efforts interact, and this, we hope, will benefit us in graduate and medical school and during our careers as researchers.

We appreciate the EID Laboratory Fellowship Program, particularly our mentors, Deborah Talkington, Division of Bacterial and Mycotic Diseases (DBMD), and Steve Monroe and Roger Glass, Division of Viral and Rickettsial Diseases (DVRD), for making this opportunity possible.

*Anne Purfield and Jennifer Tai, Class V EID laboratory fellows, will complete their fellowships in Spring 2001. Anne has spent her fellowship working in the Respiratory Diseases Branch, DBMD, and Jennifer has worked with the Respiratory and Enteric Viruses Branch, DVRD.* ■

*Jennifer Tai*

*Anne Purfield*

## NEWS BRIEFS

### Vaccine exhibit included in national time capsule

In recognition of the remarkable public health success of immunization programs during the 20th century, a selection of vaccines has been included as part of the contents of the National Millennium Time Capsule. Vaccines produced by Merck and Company–including those for hepatitis A and hepatitis B–were chosen for inclusion in the time capsule. The Hepatitis Branch, Division of Viral and Rickettsial Diseases, was recently presented with a replica of the time capsule's vaccine exhibit in appreciation for CDC's efforts in the area of immunization. In collaboration with the National Immunization Program and other government and private-sector partners, the Hepatitis Branch has developed strategies and recommendations for the use of hepatitis A and hepatitis B vaccines as a means for preventing the spread of these infectious diseases. The National Millennium Time Capsule, whose contents were chosen to represent the "pinnacle of national pride and achievement," is housed in the National Archives in Washington, D.C., and will be opened at the end of the 21st century. The commemorative replica of the vaccine exhibit is on display in CDC's Global Health Odyssey.

*Harold Margolis (L), Hepatitis Branch Chief, accepts a plaque from Thomas Vernon of Merck & Co.'s Vaccine Division. The plaque and commemorative vaccine display replica are on exhibit outside the CDC Global Health Odyssey.*

### Art Liang featured on career Web site

Art Liang, assistant director for foodborne diseases, DBMD, is among 16 scientists and other professionals featured on a Web site devoted to careers in food safety. The site, sponsored by the U.S. Food and Drug Administration, is designed for middle- and high-school students and profiles several professionals working in food safety careers. It can be found at http://www.cfsan.fda.gov/~dms/careers.html.

### Bioterrorism teleconference wins Gold Screen Award

"Biological Warfare and Terrorism: The Military and Public Health Response–Day 3," has received the first place Gold Screen Award for nationally broadcast teleconferences from the National Association of Government Communicators. The program, which aired September 23, 1999, was moderated by Bob Howard of the NCID Office of Health Communications and included appearances and input from Drs. C.J. Peters, Denise Koo, Ali Khan, and Scott Lillibridge. Carol Green and Melinda Frost of PHPPO served as coproducers of the teleconference and liaisons with the FDA and USAMRID, cosponsors of the program.

The program was a 3-day event that educated state and local public health officials about dealing with the issues associated with biological warfare and biological terrorism. The teleconference was broadcast live from the FDA studio in Hyattsville, Md., to public health departments; hospitals; and city, state, and county government agencies around the county.

## News Makers

### Staff Changes

The following persons have recently joined the Division of Healthcare Quality Promotion (formerly HIP): **Barbara Schable**, program analyst, Epidemiology and Laboratory Branch (ELB); **Ruth Skaggs**, travel assistant, Office of the Director; **Charlotta Kennedy**, program analyst, Prevention and Evaluation Branch (PEB); **Octavia Brown**, program analyst, Healthcare Outcomes Branch (HOB); **Yolanda Mackey**, program specialist, HOB; **Vernitta Love**, program specialist, ELB; and **Christine McKee-Jones**, program specialist, PEB.

**Martin (Marty) Cetron** has been selected deputy director of DQ. He has been the acting deputy director for the past year and before that assignment was chief of DQ's Surveillance and Epidemiology Branch. Dr. Cetron has been assigned to CDC since 1992 and worked in DPD and DBMD before joining DQ.

**Carolyn Collins** has recently joined the Office of Health Communication as a secretary.

**Judith Chapman** has joined the Office of the Director, DASTLR, as an office automation secretary.

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*News Makers – continued from page 9*

**Diane Hamm** has returned to DPD as program administrator, Entomology Branch. She served the Entomology Branch as a molecular biologist from 1987–1996.

**Connie Johnson** has joined DPD as program specialist, Data Management and Child Survival Activities.

**Kim Lindblade** has joined DPD as chief, Malaria Section, CDC/KEMRI field station, Kisumu, Kenya.

**John Loonsk**, formerly NCID's associate director for informatics, has joined CDC's Office of the Director as associate director for informatics and director, Information Resources Management Office.

**Barbara Moore** has joined DPD as a program operations assistant, OD.

**Dan Rosen** has joined DPD as chief of the Statistics and Data Management Section, CDC/KEMRI, Kisumu, Kenya.

## Retirements

**Helen Regnery**, chief of the executive secretariat, CDC Health Information and Surveillance Systems Board, retired February 23 after 35 years of government service. She worked many years in DVRD, serving in the Molecular Biology, Special Pathogens, and Influenza Branches.

### Attention *Focus* readers!

NCID is considering replacing the print version of *Focus* with a more frequent online version. We invite you to send your comments about format, content, frequency, readability, and other characteristics of the current newsletter to Kelly Holton, Office of Health Communication, NCID, MS-C14 (e-mail: kholton@cdc.gov).

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